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## Feedback Informed Treatment in emergency psychiatry, a poor FIT?

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# *CHAPTER 9 GENERAL DISCUSSION*

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## General Discussion

The aim of this study was to investigate the effects of feedback and the relationship between the involvement of relatives and outcome. This chapter assesses the hypotheses formulated in Chapter 1, discusses the methodological aspects of the study and presents a general interpretation of the findings, followed by a description of the clinical consequences of the implications of the results for further research. It will conclude with reflections at the meta-level about a frame of reference for the future development of psychotherapy and the position of the scientist-practitioner.

### 9.1 Evaluation of hypotheses

This section will give a chapter-by-chapter assessment of the hypotheses put forward in this thesis.

*Hypothesis 1: Applying feedback at each treatment session in a psychiatric population with severe distress results in better outcomes (fewer symptoms, enhanced well-being) and higher satisfaction than in a no-feedback condition (Chapter 6).*

Our study did not confirm this hypothesis. On the contrary, clients in TAU did better at six weeks. Contrary to our expectations therefore, we did not find that including feedback produced benefits in an emergency psychiatry setting; feedback was actually counterproductive at six weeks.

This result clearly contradicts most of the earlier studies of PCOMS, which have found substantial benefits using feedback in other treatment settings. The following possible clinical explanations for these finding should be considered:

- a reduced ability to reflect during a crisis;
- the burden on the therapeutic relationship due to the introduction of insecurity about different treatment options and outcome at the outset in a crisis situation;
- the low level of functioning and severity of the client's psychiatric problems, and the resulting possible interference with feedback effects;
- the effect size in the TAU condition was relatively high and this may have reduced the margin for any further improvement associated with adding feedback to this treatment.

*Hypothesis 2: Applying session-by-session feedback about the working alliance, goals and cooperation will improve the quality of the alliance over the course of treatment in an acute psychiatric setting. In addition, there will be greater agreement between clients and therapists in terms of their perception of the alliance (Chapter 7).*

This hypothesis could not be confirmed by our study. Neither the quality of the alliance nor the agreement between clients and therapists concerning their perception of the alliance were influenced by feedback.

Contrary to our expectations, we found no positive effect on the alliance in this sample of systematically applying feedback. To our knowledge, ours is the first study to examine the effects of immediate feedback on the alliance and the quality of the relationship using a separate measurement instrument. This somewhat limits comparability with other studies but also puts into question how the results of these studies should be interpreted.

The following possible explanations for these findings should be considered:

- The alliance may be hard to influence in the context of a relative short and intensive treatment. Pre-existing characteristics of therapists and patients may determine the quality of the alliance.
- Feedback about the alliance requires a specific attitude. It might be the case that training of a more specific kind than general instructions about feedback is required to produce the potential benefits: obtaining feedback about the alliance is a more demanding process for both the therapist and the client than discussing feedback about outcomes, and feedback about the alliance will therefore require more specific training. Training of this kind will preferably not focus on the content of the feedback but on the attitude it takes to work with feedback, on ‘deliberately practising’ with specific elements, on ‘facilitative interpersonal skills’ or on the role and the conceptual framework adopted by the therapist.
- The therapists in the Treatment As Usual condition already form strong alliances, and so there may no longer be a large enough margin for the further improvement of the alliance using formalised feedback.
- The frequent involvement of relatives could water down differences in the alliance process.

*Hypothesis 3: In a naturalistic emergency psychiatry setting in a population of patients with different diagnoses, the therapists of the CIBT team, when encouraging clients to involve relatives, will manage to involve relatives in treatment in almost all cases (Chapter 8).*

Our study partially confirmed this hypothesis.

Using a structured motivational model, it proved possible to involve relatives in the treatment of psychiatric crisis patients in about two-thirds of cases.

This could be considered a high percentage given the fact that family intervention in the treatment of patients is startlingly under-implemented and the fact that patients may have scarce contact with their relatives. However, it could also be considered a low percentage given the fact that therapists in the CIBT team were already strong advocates of the involvement of relatives. In our study, living alone was identified as a negative predictor of family involvement. Demographic factors (half of the patients in this Amsterdam cohort lived alone) may have reduced the number of treatments in which relatives were involved.

Remarkably, when patients were referred directly by their GPs, more families participated than when patients were referred by mental health services. This may reflect increased isolation from relatives in more chronic psychiatric patients.

*Hypothesis 4: Outcomes of treatments in which relatives are involved will be better than the outcomes of treatments in which no relatives are involved (Chapter 8).*

The data did not confirm this hypothesis.

On the basis of our variables, we were not able to detect any improvement in treatment outcome associated with the involvement of relatives. In the context of an open naturalistic study, this finding should be interpreted cautiously. Firstly, it is possible that involving relatives was the most beneficial option in about two-thirds of cases, while for one-third of patients an individual approach was the best option. Secondly, it was up to the relatives and the therapist to decide how many sessions they would have together. On average, this resulted in 3.2 sessions with relatives per therapy. One could argue that this was not enough to make a difference. Finally, it can be assumed that patients who objected to having relatives involved were encouraged to prove to the therapist they were able to overcome the crisis without the help of relatives and that they therefore did better than they would have done if they had not been pressured to involve relatives.

## 9.2 General methodological considerations

### Strengths of the randomised controlled trial

This study is unique, to our knowledge, in measuring the effect of applying feedback with independent measures to score outcomes and the alliance alongside the measures used for feedback. These separate instruments were used to score the symptoms and well-being of the patients as well as the quality of the working alliance as experienced by patients and therapists. The study also has considerable ecological validity since it was performed in a naturalistic setting.

Furthermore, the design with a randomised controlled trial meets all the requirements for a sound and reliable study stated by Lambert (Lambert et al., 2003): the random allocation of patients to the different study conditions, the use of different treatment methods and working with experienced and accredited care providers.

Even more importantly, the design complies with the principles of the contextual model in which feedback is rooted. All the therapists participated in both study conditions (the experimental and control conditions) and treated approximately 50% of their clients using feedback and 50% using treatment as usual. The design therefore eliminates the impact of the therapist variable, which is a crucial consideration since differences between therapists are larger in terms of treatment effects than differences between therapeutic methods (Wampold & Imel, 2015).

Another advantage of this design is that it is not very likely that allegiance factors (that is to say, therapists being enthusiastic about the method) will affect outcomes in favour of the feedback condition because all the participants received the same training for using feedback and therapists with varying levels of motivation provided treatment for the feedback group.

### Limitations of this study

A theoretical drawback of this design is that, as a consequence of possible contamination between the study conditions, any positive effects of using PCOMS may not have emerged as clearly. Since all the therapists worked in both conditions, the difference between the two conditions could have been reduced because the therapists in the TAU condition may have asked for feedback spontaneously more often, or discussed the feedback less intensively in the feedback condition. However, this would not seem to be very likely because the formalised feedback procedure in the feedback condition guarantees different

input – about the outcome – and inevitably induces a type of conversation that is different than in treatment as usual.

Another potential flaw is that, conversely, the design favours the feedback condition because therapists put more effort into patients in the feedback condition simply because these patients are more ‘in the picture’ for them. Since the results of an attitude questionnaire completed by the therapists at the start of the study show that, on average, therapists’ attitudes towards feedback were very positive, it is not unlikely that therapists favoured treatment with feedback. However, if this heightened focus on the patient is a direct effect of using feedback, one could argue that this is one of the benefits of feedback.

Furthermore, this study took place in a naturalistic crisis setting and the implementation of the study was therefore challenging in several ways.

Firstly, a pre-randomisation procedure had to be conducted rather than random assignment with a full evaluation of inclusion and exclusion criteria before initiating randomisation.

Secondly, therapies inevitably differed in duration and intensity, and there was sometimes a change of therapist during the course of the therapy. However, analyses based on observed cases, Last-observation-carried-forwards analysis and multilevel analysis – with the latter two adjusting for missing data – led to consistent results, suggesting that the overall conclusions are sound.

A drawback in the design is that patients in the TAU group completed the outcome rating scale forms only once every six weeks (to prevent bias caused by frequent ‘feedback-like’ reflection about progress in the TAU group), making it impossible to compare on-track/not-on-track trajectories between the two conditions. No conclusions can therefore be drawn about the specific effect of feedback on the group of not-on-track patients in the first six weeks. Nevertheless, the finding that the comparison of early termination and non-response in both conditions revealed no differences suggests that the early identification of not-on-track patients did not improve outcomes.

Another limitation is that no data were collected about co-existing treatment and the use of medication during the study and so it is not known whether these factors may have influenced the outcome or selective drop-out. However, in most cases, co-existing treatment is put on hold during treatment in the CIBT team, and medication is prescribed in a consistent way in both conditions since psychiatrists participate in both conditions and so it would not seem very likely that these factors have biased the results.

With regard to the study of the alliance, a limitation is that the Session Rating Scale covers different aspects of cooperation, the working alliance and the therapy process, making

it hard to determine which components of the working alliance were addressed exactly, which elements might have improved and which might have burdened the quality of the alliance. Another limitation is that many therapies involved co-therapists. This could have influenced feedback about the alliance since feedback often related to two therapists, possibly making the process of reflecting on the cooperation less personal or less precise.

Finally, we did not measure to what extent the therapists used the feedback to actually adapt the treatment approach or change their attitude.

### *The observational case study*

The study focusing on the involvement of relatives (Chapter 8) was based on secondary analyses of the data from the randomised controlled trial. The design of this study was therefore an observational patient-control study.

A strength of this study is that the actual presence of relatives in treatment sessions was recorded by a research assistant on the spot, guaranteeing an accurate count. Another strength was that an experienced and motivated team of therapists with a systemic background was involved in motivating clients to involve relatives, making the results more credible.

A limitation is that, in general, an observational study provides less evidence for causal associations than a randomised controlled trial. Since the involvement of relatives was not randomised, the results reflect only the willingness to participate and the actual availability of the relatives; no specific intervention was performed other than bringing together those who were near and dear to the client. Finally, the involvement of relatives was scored in a quantitative way only by counting the number of sessions attended by relatives. The quality of the relationship with the relatives and of the interaction was not measured.

### *Measures*

This study used measures to score both well-being (the OQ45) and symptoms (the BSI). It should be noted that previous studies, except Janse et al. (2016), have not used separate measurement instruments, apart from the feedback measures, to systematically assess the effects of feedback on either well-being or the quality of the alliance<sup>15</sup>. Reese et al. (2009, 2010) used PCOMS only; Anker et al. (2009) used only the Locke Wallace Marital Adjustment Test as a supplementary instrument during intake and follow-up. However, to check for bias due to socially desirable answers, feedback studies should use outcome

<sup>15</sup> Recently, Davidsen et al (2107) performed a study on PCOMS with a separate measurement instrument. They found no effect of applying feedback on treatment outcomes.



measures that are not identical to the feedback measures discussed with the therapist. The present study used, in addition to PCOMS, the BSI, OQ45, HAQ-II and CGI as supplementary measures to establish a more reliable picture of actual changes in well-being, symptom reduction and functioning.

The outcomes of this study showed an increase in well-being in conjunction with a reduction of symptoms over time, although the increase in well-being was slower. Furthermore, in this study, the adverse effect of applying feedback at six weeks would not have been revealed if BSI and OQ45 had not been added and only scores on the ORS had been available to interpret the effects of feedback. This finding could suggest that ORS outcomes have indeed been influenced by 'socially desirable' scoring. Finally, the mean score on the SRS for all time points in this study (33.4; *SD* 7.2) was, just as the mean scores in other Dutch samples (32.4 and 32.1), substantially lower than the scores reported in a sample from the USA (varying between 36.1 and 37.3) and it did not reach the cut-off score of 36 which is used as a guideline in the American manual to indicate an adequate alliance.

### *Sample: outpatients in crisis*

#### Composition of the study sample

In this study sample, we looked at a naturalistic mixed diagnosis sample of patients with severe psychiatric and social problems. Patients were referred to the Psychiatric Emergency Centre in the middle of a crisis and crisis assessment was followed by brief therapy. Patients were treated on an outpatient basis for a maximum of six months. Between 2009 and 2012, a total of 861 patients were referred to the Psychiatric Emergency Centre. A substantial group (222 patients) had to be excluded because they were unable to complete a questionnaire, and another group (269 patients) were offered only one session for crisis evaluation, resulting in either immediate admission to a psychiatric hospital or referral to the patient's own general practitioner/therapist. In 370 patients the crisis intervention was followed by brief therapy, which was defined as more than two sessions (including the first crisis evaluation session). Of these patients, 83 terminated treatment within six weeks, making it impossible to assess their progress at the first time point (at six weeks). The study sample therefore included 287 patients. As a group of patients (94) terminated treatment before the primary measurement point at twelve weeks or did not complete the questionnaires at this time (49 patients) or refused to participate (15 patients), a total of 129 patients had received either TAU (57) or FB (72) at 12 weeks.

Since no differences in any baseline characteristics were found between the total sample of 861 and the final study sample, this sample can be considered representative for the population in a Dutch Emergency Psychiatry Centre. The population differed from other mental health services in that patients suffered from much higher distress and that a broad mix of diagnoses was treated. However, no differences were found in this study between effects for different diagnostic categories, suggesting that the latter is no hindrance to the generalisation of the findings.

### *Sample compared to samples of other feedback studies*

Most feedback studies have been performed in psychotherapeutic settings and in samples of patients in mild distress who are generally not suffering from major psychiatric disorders. The average reported effect size from earlier studies, which mostly looked at student populations and couple therapy, was .70 (Shimokawa et al., 2010). Later studies looking at more dysfunctional populations with psychiatric outpatients (Simon et al., 2012) and inpatient eating disorders (Simon et al., 2013) found much smaller effect sizes (Cohen's  $d$  .12 and .30 respectively). This body of research was located in the United States, and in settings and with patients that may differ from those seeking mental health services in other countries. In the Netherlands, De Jong et al. (2012) performed a study of outpatients suffering from a wide range of psychiatric disorders and found no beneficial effect of feedback in their sample as a whole. A recent Dutch study (Janse et al., 2016) – a practice-based longitudinal study with a non-equivalent control group design – looking at patients with a variety of psychological problems in an outpatient setting also found that feedback had no effect. Recent research (De Jong, 2016, in press) showed that, in patients diagnosed with borderline personality disorders and patients diagnosed with PDD NOS, immediate feedback had an adverse effect.

The present study focused on a psychiatric population in severe distress – patients referred in the middle of a crisis – with crisis assessment being followed by brief therapy. We found that feedback actually had an adverse effect after six weeks.

Davidson et al. (2015) concluded that the available studies in psychiatric samples show that feedback improves outcomes for those with more severe mental health problems but that effect sizes are smaller than in studies looking at psychotherapeutic samples. The present study supports the conclusion that feedback is less effective in samples of patients with more severe problems.

The level of distress and the psychopathology of the participants are factors that distinguish this population from most samples in other mental health services, and the findings of this study should therefore be interpreted cautiously. For instance, 15% of the participants in this study sample were diagnosed with psychosis, while the recent review of the Cochrane Library on feedback excluded studies in which the total number of participants with a diagnosis of psychosis made up more than 10% of the sample (Kendrick et al., 2016).

### *Comparison with therapists and settings in previous studies using PCOMS*

The effect of the feedback system PCOMS has previously been studied in randomised trials only in a student population and in couples presenting for relation therapy (Reese et al., 2009 and 2010; Anker et al., 2009). Some treatments in the American studies of the student population were delivered by students; all the therapy for couples was delivered by second-year students. Treatment in the Norwegian study (Anker et al., 2009) was delivered by experienced family therapists.

The Dutch study by Janse et al. (2016) looked at treatment delivered by experienced therapists. The treatment in the current study was delivered in an Emergency Psychiatry Centre by a group of 19 highly experienced therapists, who also worked with a group of experienced and intensively supervised residents in psychiatry.

The US studies and the Norwegian study found that feedback had a substantial positive effect; the Dutch studies found that feedback had hardly any effect and the present study actually found an adverse effect. On the basis of these findings, it could be concluded that PCOMS is mainly effective in therapy for couples and in individual therapy when delivered by inexperienced therapists to patients in relatively mild distress.

Furthermore, as has been mentioned earlier, a separate measurement instrument was used to measure outcomes only in two studies besides the present study. Since the data from the present study suggest that results can be affected by socially desirable scoring, the findings of studies without separate measurement instruments could be biased by such socially desirable scoring. Taken together, these results cast doubt on the idea that PCOMS is effective as an instrument for improving therapy outcome in general.

### 9.3 General interpretation of findings

#### *The feedback study*

The present study suggests that session-by-session feedback has no added value in a population of patients in emergency psychiatry. This finding can be interpreted in the light of situational factors, patient factors and therapist factors.

Turning to the situational factors first: we can hypothesise that, in crisis situations such as acute post-traumatic stress, high anxiety, acute grief and acute suicidality, the ability of clients to reflect is impaired to such an extent that they cannot benefit from feedback at all.

As for the patient characteristics, we can follow the same line of thinking and hypothesise that feedback will not be effective either in clients with a personality structure that leaves little room for reflection.

As for therapist factors, we can hypothesise that a negative effect of feedback is partly the result of the undermining of the therapist's role by the feedback. This applies in particular to the situation in which a therapist who adopts the expert role asks for feedback about the alliance; it is reasonable to assume that patient faith and trust in the expert are undermined when the expert questions his own actions and indicates that it is not certain that the treatment will be effective. This implies that, if the therapist adopts the expert role, formal feedback about the outcome will be appropriate but feedback about the alliance will not.

It is still an open question to what extent patient factors, therapist factors and situational factors influence the effect of feedback. For instance, Janse et al. (2016) found that outcome was only improved specifically with mood disorders in the feedback condition. In our study, we found no differences between diagnostic categories. Anker et al. (2009) found that less effective therapists benefited more from feedback than more effective therapists. Our study is inconclusive about this question since the small number of patients per therapist and the high frequency of co-therapy precluded conclusions in this area.

In any case, the results of this study suggest that the form of the feedback process has to be tailored to the patient and the context, an idea that concurs with research that shows that therapists who follow the textbook strictly are less effective than therapists who demonstrate 'adherence flexibility' and who therefore improvise regularly (Owen & Hilsenroth, 2014). Even more importantly, the desirability of tailoring feedback is in line with the premises of the contextual model, which indicate that every intervention should be assessed at the level of the specific patient-therapist pairing.

Finally, even if the outcome of the therapy is not affected, outcome feedback can be valuable. It can help the patient decide when to terminate the therapy and it allows the therapist to learn from the way patients respond to him and to evaluate whether he is doing his job well enough (Miller et al., 2015). Outcome feedback makes it possible to assess effectiveness at the therapist level instead of at the treatment-model level.

### *The study of the involvement of relatives*

Despite the vast evidence base for family involvement and family psycho-education, research suggests that family involvement is often not included in routine mental health care (Eassom, 2014; Maybery et al., 2014; Kim and Salyers, 2008). Families still feel marginalised and distanced from the care planning process. Eassom et al. (2014) state that involving the family brings additional challenges other than those generally associated with translating research into practice. It requires a cultural and organisational shift towards working with families that is supported by strong leadership. But it also requires thinking of the family as equal partners and thinking more systemically about problems; and it requires time and is difficult to integrate with other clinical work. So family work is only feasible if it is a goal shared by all the members of a clinical team, including the leaders of the organisation, and if the ethos and practices of clinical teams and the working routines facilitate family involvement.

The CIBT team that provided treatment in the current study fulfilled the requirements mentioned above. It had established routines and a shared ethos for working with relatives, the management supported family involvement, therapists were trained to work with families, and working routines facilitated engaging families in treatment (van Oenen et al., 2007; see also Chapter 2 about the roles of the therapist and Chapter 3 about attunement). This background probably explains in part why the therapists in this study managed to get relatives involved in the majority of cases.

In addition, in line with this systemic approach, a motivational model was used to encourage relatives to get involved. Firstly, the referring professional encouraged patients to bring a relative to the first session. Secondly, if no relative was present at the first session, patients were asked to invite a relative to the next session. Thirdly, reluctant patients were actively encouraged to contact a relative. Fourthly, when there were serious concerns about the safety of a patient, the therapist would get in touch with relatives and invite them to a session, even when patients were reluctant. All the relatives were told that their presence was crucial if the therapist was to offer the best possible treatment.

We found that it was possible with this structured motivational model to involve relatives in the treatment of psychiatric crisis patients in about two-thirds of cases. This can be considered a high percentage given the fact that family involvement in the treatment of patients is startlingly under-implemented. Even more so since demographic factors may have reduced this percentage given the fact that ‘living alone’ was identified as a negative predictor of family involvement and half the patients in this Amsterdam cohort lived alone. However, this percentage can equally be thought of as being low given the fact that therapists in the CIBT team were strong advocates for the involvement of relatives and relatives were still not involved in one-third of cases. Given the strong motivation of the team to involve relatives it seems reasonable to conclude that about one-third of patients wish to solve their problems on their own and will not agree to any relative involvement whatsoever.

On the basis of our variables, we were not able to detect any improvement in treatment outcome associated with the involvement of relatives. In the context of an open naturalistic study, this finding should be interpreted cautiously. However, if the findings are considered to be indicative for the relationship between treatment outcome and the involvement of relatives, some hypotheses can be formulated. Firstly, involving relatives may be beneficial in about two-thirds of cases, with an individual approach working best for one-third of the patients. Secondly, more than three sessions with relatives are needed to make a difference.

Finally, patients who persistently object to the involvement of relatives may be challenged to overcome the crisis without the help of relatives and therefore do better than they would have in the absence of this challenge. This means that relatives (and therapists) have to accept that one out of three clients will not agree to a systemic approach to treatment and that these clients will probably solve their problems just as well on their own.

Furthermore, since this study did not measure the burden on relatives or the satisfaction of relatives, no conclusions can be drawn about the implications for them. It may be that the involvement of relatives was useful for these relatives, even if the patients themselves did not report a better outcome.

## 9.4 Clinical implications

### *Clinical implications of findings*

1. To our knowledge, this is the first study suggesting that immediate progress feedback in psychiatric practice does not improve outcome and actually has an adverse effect in the first six weeks of crisis/emergency treatment. So it can be concluded that it is better not to use immediate feedback for patients in crisis situations.
  
2. Based on our finding that immediate feedback can have an adverse effect on patients in crisis situations, a more far-reaching tentative conclusion might be that therapists should be aware that it is better not to use immediate feedback in some situations or with some patients. The feedback method should therefore be appropriate for the actual situation and the particular client, which means that less frequent or less direct feedback methods should be considered in some situations.
  
3. The adverse effect of applying feedback at six weeks found in this study would not have been revealed if no other measure had been added and ORS scores only had been available to interpret the effects of feedback. This finding suggests that ORS score outcomes are affected by ‘socially desirable’ scoring and that they should therefore be interpreted cautiously in clinical practice.
  
4. Our results suggest that adding the alliance-oriented SRS form has no added value in the feedback process. Since therapists in this study formed good alliances anyway, the result may indicate that formalised feedback does not have any added value when the quality of the alliance is good. Furthermore, this finding could mean that the positive results of applying feedback found in the past are linked to feedback about outcome scores (ORS) and not to alliance feedback. The clinical implication of this finding could be that formal feedback about the alliance should not be included in feedback instruments at all. However, this study cannot be used to draw firm conclusions about this subject.
  
5. The mean score on the Session Rating Scale for all time points in this study was – just as in other Dutch studies and in a Norwegian study – lower than the scores reported in the US samples and below the threshold score (indicating that the quality of the alliance is adequate ) mentioned in the US manual. This could mean that the alliance between patients and their

therapists in the European studies was inadequate but it could also mean that alliance scores should be interpreted in the cultural context and in the context of the specific treatment and patient. For now, our conclusion is that a fixed threshold score should not be used to assess the quality of the alliance that is required as a minimum.

6. When therapists use a structured motivational model to encourage patients to involve relatives, it proved possible to involve relatives in the treatment of psychiatric crisis patients in the majority (two-thirds) of cases. This is much higher than in other studies in which no systematic model to motivate patients was used. Since the importance of the involvement of relatives in treatment in emergency psychiatry is widely accepted, our data suggest that therapists should, in these situations, systematically try to motivate patients to contact their relatives.

7. In our study, the outcomes of the treatment – including patient satisfaction – were similar for treatment with and without the involvement of relatives.

Since research also shows that relatives appreciate participating in treatment, and that patients may benefit from involving relatives in ways that were not measured in this study, there is no need for therapists to be reticent about involving relatives in treatment.

### *Clinical implications on a meta-level: the paradox of the scientist-practitioner*

The author himself has experienced a role change from 'believer' to 'scientist' with regard to the subject of this thesis. This thesis also reflects both positions. The 'believer' article about feedback (Chapter 4) reflects the starting point: belief in an inspiring idea. The 'scientist' articles (Chapters 5-8) reflect the results of the study: the expected effect cannot be demonstrated and an adverse effect was actually found at six weeks.

This reflects a contradiction all therapists have to deal with in some way: the 'Dodo Bird verdict' tells us that all models are equally effective but therapists are tempted to believe that their preferred model is more effective. The latter is not surprising for several reasons. Firstly, all other stakeholders in mental health care ignore the Dodo Bird verdict. Creators of new models invariably promote their treatment approaches as 'new and better', professional psychotherapy associations oblige their members – throughout their professional career – to master new models and to 'update their skills', institutions force their employees to qualify for 'the most effective models' in order to meet the requirements of insurance companies that



want to demonstrate that they offer ‘value for money’, all cheered on by patients who demand ‘the best possible treatment’.

This results in a paradoxical situation faced by anyone who accepts the Dodo Bird verdict: while rationally knowing the method he applies has no specific added value, he continuously has to master and apply new methods to comply with the demands of all stakeholders in mental health care.

Many therapists cope with this paradox by preferring to believe that the new model they are mastering works better than the old one, an understandable position since it is more convenient to learn or apply a model in which one has faith.

Remarkably, in one sense, therapists are right to do so since research shows that the success of treatment is positively related to the belief of the therapist in the method delivered, the ‘allegiance’ (Falkenstrom et al., 2013), and the magnitude of this allegiance effect (in researchers and therapists) ranges up to .65 (Wampold & Imel, 2015).

On the basis of these arguments, one could argue that therapists should ignore the Dodo Bird verdict and search for inspiration from new models again and again. Not surprisingly, this is what quite a lot of therapists actually do. However, ignoring this paradox has its price. It creates an unending search for ‘the better model’ that involves endless amounts of money and energy. For instance, Laska et al. (2014) calculated that eight studies comparing models costed more than 11 million dollars, without producing any actionable results other than the conclusion that no differences were found. Even more importantly, therapist confidence is inevitably undermined when they are told over and over again that the model they are now wholeheartedly applying is inferior and that they should master a better model. On top of this, unrealistic expectations of patients are boosted by the suggestion that unsuccessful treatment could have been avoided if the latest scientific insights had been applied properly, suggesting that in the end the science will come up with solutions for all problems.

Seen in this way, the paradox is damaging for all participants in mental health.

Therapists and scientists should therefore make it clearer to all stakeholders in mental health that the results of scientific research about the efficacious elements of the therapy process are limited, and that neither the frame of reference nor the treatment method are related to treatment success. And that the ability to connect to the inner world of the patient and relatives is probably crucial to treatment success implying that the empathy and communication skills of the therapist are the most essential components of the therapy process.

Accordingly, it should also be made clear that the unique personal characteristics of both the therapist and the patient have a major impact on the outcome of the treatment and that therapy is therefore a joint quest for answers and solutions with no guaranteed outcome. Finally, although it is unsatisfactory on a scientific level, the Dodo Bird verdict creates a surprising degree of freedom for the clinician, who can adopt any approach he wants as long as it suits him well. In other words, as long as a therapist looks to see whether a treatment is appropriate for the client, whether the treatment is accepted by the client and whether the client responds to the treatment. When there are difficulties with client acceptance and/or response, the therapist is free to try any other approach in which both he and the patient have faith. In that case, inspiring essays can help the therapist to choose an approach that is intuitively appealing. The sole limitation is that he must operate within ethical boundaries and be willing to evaluate the method adopted and the effects in a critical way.

This means that scientist-practitioners must accept, at present, that they are constantly seeking an optimal balance between unreliable intuition and limited knowledge. As the philosopher Schumpeter (1943) wrote: 'To realize the relative validity of one's convictions and yet stand for them unflinchingly is what distinguishes a civilized man from a barbarian.' Dealing with paradoxes of this kind requires what Aristotle called "phronesis": practical wisdom. Ultimately, therefore, wisdom can be seen as the core quality of the scientist-practitioner. And, in order to make sure that this wisdom actually generates added value in terms of the practical realities of the patient, the scientist-practitioner should regularly test his wisdom in the light of the patient's views and those of the people who are near and dear to the patient. Indeed, by asking patients for feedback and involving relatives in the treatment...

## 9.5 Directions for future research

### *Directions for future research based on the findings of this study*

Firstly, research will be needed to determine whether feedback is affected by pre-treatment functioning and the patient's ability to reflect. Future feedback studies will therefore have to measure the level of distress and severity of symptoms at the start of treatment. In addition, patients' ability to reflect ('mentalisation') should be measured by scoring patients' levels of reflective functioning at the outset of therapy.

Secondly, feedback studies should include independent outcome measures to control for 'socially desirable' scoring during the feedback process.

Thirdly, future research should make it clear whether immediate alliance-oriented feedback can affect the quality of the alliance and, depending on the outcome, whether formal feedback about the alliance should be included in feedback instruments.

Fourthly, future research should take the impact of the therapist variable into account in the study design. Since differences between therapists are larger than differences between therapeutic methods in terms of treatment effects, differences due to therapist variables should be eliminated. This means that all therapists should preferably participate in both study conditions but that, at the same time, bias due to therapist allegiance should be taken into account.

Finally, a randomised study is needed to determine whether involving relatives in treatment during a crisis situation has added value for clients. However, a study of this kind will not be easy to implement. Future research should also include the evaluation of the outcome for relatives.

Furthermore, the mean number of sessions in the group with relatives involved was higher in this study than in the group without involvement of relatives. A randomised design is therefore needed to explore the nature of the relationship between relative involvement and the number of sessions.

#### *Future research on a meta-level: medical model, contextual model and beyond*

As mentioned in the introduction, feedback is rooted in the contextual model which aims to offer an alternative to the treatment-model-oriented approach of the medical model. The medical model and the contextual model have elements in common but they differ in their research focus. The medical model focuses on RCTs in which – in extremis – individual patients and therapists are not supposed to be active agents and are therefore neutralised as much as possible in the design of the studies.

By contrast, the contextual model focuses on patient-focused research, assuming that the therapist and client are the key factors in the effect of therapy. The personal characteristics and qualities of the therapist and the preferences and characteristics of the client, as well as the match between the two, are therefore considered to be vital elements in the design of studies (Barkham et al., 2010).

In other words, practice-based evidence fosters patient-focused research, in which the effectiveness of each treatment and each therapist is monitored, in each individual case, to verify whether there is a good fit and an adequate effect. By contrast, evidence-based practice fosters model-focused research in which the efficacy of a treatment model for a patient

population is measured to verify whether the model works for the average patient in the sample.

Although there are differences between the two models, they also have elements in common. At a collective level, patient-focused therapy aims to pool data so that it can contribute to and enhance the evidence base for the psychological therapies (Barkham et al., 2010); this aim is in line with the principles of evidence-based practice. Furthermore, evidence-based practice honours individual clinical expertise, and is based on the idea that it is this expertise that serves to decide whether the external evidence applies to the individual patient at all (Sackett, 1996); this idea is close to the aim of practice-based evidence to privilege the role of the practitioner as a central focus.

Despite the similarities between the models, both models represent different views about how the psychotherapy field should develop. Evidence-based practice stresses the importance of developing new and better treatment models and identifying specific elements that should be proven effective in RCTs, while practice-based evidence stresses the importance of monitoring the effectiveness of individual therapies and identifying common factors.

From the perspective of the medical model, one might argue that the medical model could be enriched by incorporating the contextual model. In this view, direct comparisons of treatment options in RCTs will still be the gold standard, but patient and therapist factors will be considered to be active agents as well, and they will not be assumed to be neutral or be neutralised as much as possible in the design of the studies. However, it is questionable whether RCTs are a suitable format for personalised research of this kind.

From the perspective of the contextual model, a radical point of view could be that research should be organised the other way round. The effectiveness of therapists in clinical practice will be monitored, the most effective therapists will be identified and their activities will be studied to find out what makes a therapist a ‘supershrink’. However, no breakthrough can be expected at present in this complicated field of research.

Ultimately, both models have in common that they trust in the ability of scientific research to identify effective ingredients in therapy or in therapists. Time will tell whether one of the two models will lead to more effective treatment. In the meantime, an even more radical point of view has to be considered (Keeny, 2009): that the field of psychotherapy should not in the first place be approached as a science-based domain but as an art-based domain. From this point of view, scientific research is not the optimal way to develop the field of psychotherapy in the future. In this view, scientific research is the framework around

the artwork and its function is therefore to stake out the boundaries (ethical and otherwise) of the art, to distinguish it from other domains that are better approached from different perspectives (scientific or otherwise) and to contradict any unrealistic claims of the art. With respect to the parallel between art and psychotherapy, we can keep in mind the way art was defined by the famous writer Kloos: 'the utmost individual expression of the utmost individual emotion'. One can hardly think of a better way to characterize the core of psychotherapy.

If we take these considerations to heart, future research should focus on the strictly personal elements associated with the therapist, the patient and the relatives that influence outcomes, and on elements that boost the healing ritual. This implies that research should shift its focus from quantitative to qualitative studies.

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